STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005007	A. BUILDING _____ B. WING _____	08/29/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY HOWARD REGIONAL HEALTH INC	3500 S LAFOUNTAIN ST KOKOMO, IN 46904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for a standard licensure survey. Facility Number: 005007 Survey Date: 8/27, 28 & 29/2012 Surveyors: ReBecca Lair, LCSW Medical Surveyor Karilyn Tretter, RN Public Health Nurse Surveyor Lynnette Smith Medical Surveyor Community Howard Regional Health is in compliance with 410 IAC 15.1, Hospital Licensure Rules. QA: claughlin 09/06/12	S 000		